WELCOME TO OUR OFFICE!

Thank you for the following information, which will help us establish your file and provide you with the best possible care.

Legal Name (First, M.I., Last)_____ Appt. Date_____
Preferred first name or "nickname" (if other than legal name above)_____
Birthdate _____ Age _____ Sex: M F Employer or School _____
Current Occupation/JobTitle (grade or major for students) _____
Responsible for Account: □Myself □Spouse □Self & Spouse □Parent(s) □Guardian(s) □Other
Account/Responsible Party Name(s) (if other than yourself)_____
Account Mailing Address _____
Email _____ Home/Account Phone _____
Work Phone _____ Cell Phone _____

We sincerely appreciate that you have selected our office. May we ask how you made this choice?
□ Acquaintance..Name(s)? _____ □ Other Doctor..Name? _____
□ Household/Family members previously seen here---name(s) _____
□ Website/Internet □ Newspaper □ Phone Book □ Location □ Other _____

Please indicate all that you wish to accomplish during this visit: □ General Eye Health and Vision Exam
□ Needing/considering updated frames and/or lenses □ Currently wearing (or considering) contact lenses
□ Evaluation for specific condition, disease, or problem(s): _____
□ Adjustment or repair of current eyeglasses □ Other _____

To help the doctor and staff serve you effectively, please indicate wherever applicable:
Current/recent ocular symptoms or problems _____
_____
Approx. Date of Last Professional Eye Exam _____ Previous Eye Doctor _____
Do You Currently:
□ Have only one pair of glasses in good condition?
□ Have public contact or speaking responsibilities?
□ Ever feel a need for prescription sunglasses?
□ Have trouble with glare or reflections at night?
□ Want information on thinner, lighter lenses?
□ Ever seem sensitive to bright sunlight?
□ Want information about corrective laser surgery?
□ Have eyestrain/fatigue with reading or computer?

Financial Arrangements
□ Optical Insurance? Plan name_____ □ Medical Insurance? Plan _____
(Please bring and present insurance card(s) and/or forms to receptionist upon arrival)

Except for amounts covered by "participating" insurance plans that reimburse our office directly, payment is requested on the date of service. **A 25% prompt payment discount is applied to professional services paid at the time of service by cash, check, VISA, Mastercard, or Discover.** We also offer **Care Credit**® no-interest monthly payment financing as an alternative to credit cards (application and online approval available in minutes at our office). Please indicate your preference for settling your account at this appointment:

□ **Check** □ **Cash** □ **Credit Card** □ **Care Credit® Financing** □ **Other _____**

Signed (Patient or Responsible Party) _____

Thanks for allowing us to serve you!